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IN THE

Supreme Court Of The United States

October Term, 1982

JEFFERSON PARISH HOSPITAL DISTRICT No. 2 and EAST JEFFERSON HOSPITAL BOARD,
Petitioners

versus

EDWIN G. HYDE,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, EDWIN G. HYDE

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QUESTION PRESENTED

Whether an exclusive contract entered into by and between a hospital and an anesthesiologist group to attend the hospital's patients is unlawful *per se* under the Sherman Antitrust Act, 15 U.S.C. §1, because it "ties" the patient's use of the hospital's operating rooms to the use of the hospital's anesthesiologists.

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BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, EDWIN G. HYDE

INTEREST OF *AMICUS CURIAE*

Pursuant to Rule 36 of the Rules of this Court and with the consent of all parties,[1] the Association of American Physicians & Surgeons, Inc. (AAPS) respectfully files this brief *amicus curiae* in support of the Respondent, Edwin G. Hyde.

AAPS is a voluntary association formed in 1943 by private, practicing physicians and surgeons. AAPS is incorporated under and by virtue of the laws of the

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[1]Letters of Consent have been filed with the clerk.

State of Indiana, and has its principal office located in Burke, Virginia. AAPS is the largest association with nationwide membership in the United States devoted exclusively to representing the private, practicing physician and surgeon. AAPS has members in every state and territory in the United States, and in the District of Columbia.

Exclusive contracts between hospitals and anesthesiologists have been a long-time concern to the membership of the AAPS.[2] Fundamentally an organization dedicated to encouraging competitive practices in medicine and health care, the AAPS has always viewed exclusive contracts in hospitals with providers of anesthesiology as restraints upon trade. The AAPS, within its membership, represents many anesthesiologists nationwide. Nearly all enjoy practices which do not encompass exclusive contractual arrangements. Some face situations where exclusive contracts have been entered into by and between hospitals and competitor anesthesiologists. Those members know and understand the regrettable situation in which Edwin G. Hyde is placed. Most AAPS members, however, have practiced and continue to practice medicine in hospitals where multiple practioners of the specialty of anesthesiology enjoy vigorous practices.

The members of the Association of American Physicians and Surgeons, Inc., are private, practicing physicians and surgeons, and believe that quality as well as price fairness to the paying consumer of health care

[2]All arguments herein are equally applicable to exclusive contracts between hospitals and radiologists.

is best achieved through vigorous competition. The members of AAPS know only too well that health care has been, for many years, dominated by practices which are anticompetitive, and, consequently, those practices have denied entry into the market place of practitioner-competitors; prohibited innovation and alternative methods of health care delivery; and blocked practices aimed at allowing prices for services to be dependent upon competitive forces of the marketplace.[3] The members of the AAPS know that medicine has been traditionally controlled by a medical "cartel", be it the medical staff of a hospital, in conjunction with the institution, the county medical society, and/or state medical association. To the members of the Association of American Physicians & Surgeons, Inc., exclusive contracts are but another example of a threatened stagnation of competition in health care which, among

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[3]Cases heretofore decided by this Court illustrate the anticompetitive practices in medicine and health care. "Organized medicine" blocked the establishment of prepaid health clinics. *American Medical Association* v. *United States*, 317 U. S. 519 (1943). "Organized medicine" inhibited physician advertising. *In re American Medical Association*, 94 F.T.C. 701 (1979), *aff'd*, 638 F. 2d 443 (2nd Cir., 1980), *Aff'd* ____ U. S. ____, 102 S. Ct. 1744 (1982). A county medical society sought to organize its membership and negotiate fixed fees for health care services with insurance companies. *Arizona* v. *Maricopa County Medical Society*, ____ U. S. ____, 102 S. Ct. 2466 (1982). Reimbursement practices carried on between organizations of health care practitioners and insurance carriers were alleged to be vehicles whereby prices were potentially fixed (such as in the insurance claims "peer review" process), and patients were allegedly discouraged from using alternative forms of health care. *Union Labor Life Ins. Co.* v. *Pireno*, ____ U. S. ____, 102 S. Ct. 3002 (1982); *Blue Shield of Virginia* v. *McCready*, ____ U. S. ____, 102 S. Ct. 2540 (1982).

other things, will rigidly maintain a price structure for which no market forces will exist to lower or make more reasonable, and will discourage entry into the market of any and all competitive forces.

Accordingly, it is important to the members of the Association of American Physicians & Surgeons, Inc., to present facts which would illustrate how exclusive contracts, in truth, must be viewed, and, how hospitals and their medical staffs interact with respect to exclusive contracts.

For all the foregoing reasons and purposes, AAPS files the within brief *amicus curiae* in support of the Respondent, Edwin G. Hyde.

SUMMARY OF ARGUMENT

The issue in this case is whether an exclusive contract entered into by and between a hospital and an anesthesiologist group to attend the hospital's patients is unlawful *per se* under the Sherman Antitrust Act, 15 U.S.C. § 1, because it "ties" the patient's use of the hospital's operating rooms to the use of the hospital's anesthesiologists.

A. Practically speaking, an exclusive contract to perform anesthesiology entered into by and between a hospital and an anesthesiologist is, by its nature, anti-competitive. Since only one provider (or provider group) performs all anesthesiological services, other competitor-providers in the specialty are denied admission to the medical staff of the hospital, or, if they have hospital medical staff privileges, the same are revoked. Competing providers are excluded.

As a result of any exclusive contract to provide the services of a medical specialty, various inner-hospital and inner-hospital medical staff competitive factors are eliminated, and, accordingly, the price or prices for the medical specialty services will receive no stimuli to decrease, and will always spiral upward. As well, quality, also dependent upon competitive market factors, will be adversely affected.

B. Exclusive contracts in anesthesiology are, by no means, an old phenomenon. They are, in fact, quite new as a national impetus to implement among hospitals. Accordingly, to affirm the Court below would not affect hospitals generally. However, if the Court below is not affirmed many competing health care providers will be excluded from competition, and young providers denied entry into existing markets.

C. The hospital is always the dominant force in its relevant health care market. That market is quite small and well-defined. The hospital's market consists of that area within which the physicians and surgeons on its medical staff maintain their offices and residences, and, where would-be patients may conveniently and speedily be taken to the hospital. The foregoing is true since patients are admitted into the hospital through two channels. First, the patient's physician or surgeon admits him or her to the hospital where the provider enjoys admitting privileges. Such represents the vast majority of hospital admissions. If a patient is admitted through a means other than the foregoing, it is because of convenience of location. Therefore, within the area where its staff physicians

maintain their offices and residences and where the patients may conveniently or speedily be admitted, the hospital "dominates" the market in the provision of its environment within which health care services are offered. A hospital, therefore, possesses sufficient power in the various tying markets to coerce the purchase of tied "products".

D. Exclusive contracts by and between hospitals and anesthesiologists are "tying arrangements" and, accordingly, are *per se* violations of the Sherman Act. Since the same standards for the application of the antitrust laws must apply to health care as any other industry, the instant contract must be viewed with the same light this court viewed the purposes of the Sherman Act in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958). And, as physicians and surgeons are "individual competing entrepreneurs," combinations or contracts which restrain trade entered into by them should be viewed harshly. Here, since the hospital has the market power to control access to its operating rooms, the exclusive contract coerces a patient to utilize the exclusive anesthesiologist. As such it is a *per se* violation of the Sherman Act. *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958); *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982).

E. The defense that exclusive contracts insure "quality health care" cannot pass muster since quality, like price fairness, is dependent upon the interplay of those market factors created by competition. The ex-

clusive contract eliminates all of the market factors which competition insures.

F. The exclusive contract is not a verticle integration. It is not an employment by the hospital of a health care specialist. Rather, the exclusive contract recognizes the anesthesiological group as private, practicing providers. They submit their own statements for services rendered.

Further, the hospital is not similar to a manufacturer at the end of process of production involving "levels" of jobbers or dealers. Instead, the hospital provides an atmosphere and "place" where "independent, competing entrepreneurs" provide health care services. The medical staff consists of many providers. It is organized by bylaws entered into with the hospital. Admission to the medical staff and consulting regarding medical procedures are, fundamentally, medical staff decisions. Accordingly, the relationships within a hospital are horizontal, not verticle.

As the exclusive contract recognizes the private, practicing provider status of the anesthesiological group, and, recognizes said provider group as part of an autonomous medical staff which is the fundamental decision-making body in the institution, the relationships are, indeed, horizontal. If the hospital sought to employ the anesthesiologists, it would have "employed" them, not awarded an exclusive contract. The exclusive contract must be viewed under the *per se* rule, and must be deemed a violation of the Sherman Act.

ARGUMENT

I

EXCLUSIVE CONTRACTS BETWEEN HOSPITALS AND ANESTHESIOLOGISTS ARE, BY THEIR NATURE ANTICOMPETITIVE

Exclusive contracts between hospitals and anesthesiologists are, practically speaking, anticompetitive. Simply, the hospital and its medical staff determine that one provider or one provider group shall perform all of the anesthesiological work in the institution. New providers coming into the market covered by the hospital are barred. Existing provider competitors are prevented from continuing their practice with the institution of the exclusive contract with the contracting provider.

Importantly, most exclusive contracts to provide anesthesiological services include, within their terms, agreements respecting price. AAPS members are aware of exclusive contracts which stipulate the prices which must be charged by the provider for each function or service offered. The instant case, as well, provides evidence of agreement between the hospital and the exclusive contractor relative to the price or prices for anesthesiological services.

Petitioners' argument regarding the long-standing and traditional practice of providing anesthesiology services through exclusive contracts is not well taken. Many hospitals have never instituted such practices. Most AAPS members who are anesthesiologists have practiced their specialty without such contracts. They represent specialists from all across the nation. Only

recently have AAPS members detected a national impetus among hospitals and hospital administrators to encourage entry into exclusive contracts with certain specialties. As a result, thousands of practicing anesthesiologists face the growing threat of being excluded from practicing their profession. Manifestly, exclusive contracts have not been uniformly utilized nationally. Their attempted wide-spread use is but a very recent phenomenon.

Where many providers of anesthesiological services may be excluded from practicing their specialty through such exclusive contracts, the paying consumer of health care services (patient, insurer or employer), as well, faces a bitter problem. With the advent of an exclusive contract between a hospital and an anesthesiologist, no incentives will exist to provide the services at lower cost. The exclusive contract provides a built-in guarantee that the cost for such health care services will only increase. No inner-hospital or inner-hospital medical staff competitive factors will remain to encourage fair pricing of the services rendered. Irrespective of whether a hospital is incorporated under the "non-stock, non-profit" corporation laws of its state, it nevertheless evidences a profit motive. Naturally, the members of the medical staff of the hospital, including anesthesiologists, have a definite profit motive. Though AAPS members applaud the profit motive (as Petitioners apparently do), exclusive contracts are abhorrent to all concepts of economic fairness. Accordingly, they are a nightmare for the paying consumer.

The exclusive contract eliminates any and all incentives to reduce or stabilize price or utilization. To that question the Court below addressed itself with particular force. The Court recognized that in anesthesiology much of the work is performed not by the anesthesiologist, but by anesthetists whose time is billed by the hospital to the patient. The more the anesthesiology department is controlled by the hospital administration, the greater the hospital's billing. And, irrespective of whether the anesthesiology provider with whom the hospital has contracted is lower-priced initially, from the date of the exclusive contract forward, no market incentives exist for either the hospital or the contracting professional to lower or stabilize price or utilization.

Unequivocally, exclusive contracts are neither a traditionally-accepted form of practice nor a universally-adopted one. As a national impetus, they are quite new. As such, their impact will force many health care providers in the relevant specialties out of business. Those providers otherwise would compete with their fellow providers in anesthesiology. Exclusive contracts, as well, will prevent new providers from entering a given market, and, will eliminate all those inner-hospital and inner-hospital medical staff market factors which protect the paying consumer from ever-increasing costs.

In every sense, exclusive contracts by and between hospitals and anesthesiologists restrain trade.

II

THE HOSPITAL IS ALWAYS THE DOMINANT FORCE IN ITS RELEVANT MARKET

Hospitals, fundamentally, receive patients through two channels. First, patients *are sent* to a particular hospital because their doctor is a staff member. Second, patients *choose* a hospital because of its close proximity to their home. For the most part a patient is admitted to a particular hospital because of his or her doctor. Patients generally do not request a specific hospital. As the Court noted below, the prevalence of third-party payment of health care bills eliminates the incentive to compare the relative cost effectiveness of competing hospitals. Likewise, most patients rely upon their physician or surgeon to inform them of the quality of medical care, and generally such a discussion is avoided when the doctor simply tells a patient, "I'm going to admit you to _____ hospital." The hospital in which the patient is admitted is one in which the physician or surgeon enjoys admitting privileges.

Where a patient has been involved in an accident or is in the midst of an emergency, he or she always chooses the hospital closest to home. When a patient chooses to enter a hospital, the hospital chosen is, customarily, close to family, friends and home.

It has been the universal experience of AAPS members that the above factors represent the reasons for the selection of one hospital over another. Accordingly, the Court below infused a very healthy and long-overdue realism in its opinion when it found the defi-

nition of the hospital's relevant market established by the District Court to be in error.

Unequivocally, economic concerns do not form the basis for most patients choosing one hospital over another. These days most patients do not pay the total medical and hospitalization bill. It is unrealistic to assert that most patients would be concerned about costs when third-party payers are paying for upwards of eighty percent of the health care services.

A hospital's relevant market is the relatively small geographic area which surrounds it. Most of its medical staff members choose to apply to the medical staff because of the close proximity of the hospital to their offices and homes. They may easily make their rounds during the day, and may make emergency calls at night without driving across town. Within that geographic area where its active medical staff members have established their offices, and, where would-be patients find it convenient to be admitted, the hospital reigns as the dominant force in the health care market.[4]

Irrespective of what Petitioners offer as the relevant market for a given hospital, the foregoing is *universally* true. The Court below was positively correct in its assessment of a hospital's market.

As a hospital possesses sufficient market domination within its geographic area, it possesses, as well, the power in various tying markets to coerce the pur-

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[4]The foregoing is underscored by the national trend among hospitals to construct their own medical offices adjacent to the hospital, and encourage admitting staff members to rent office space in such structures.

chase of tied "products." To deny that, the AAPS submits, is to deny the realities of the provision of health care today.

III

EXCLUSIVE CONTRACTS FOR ANESTHESIOLOGISTS ARE "TYING ARRANGEMENTS" AND, AS SUCH, ARE *PER SE* VIOLATIONS OF THE SHERMAN ANTITRUST ACT

A. The Same Standards for the Application of the Federal Antitrust Laws Which Have Been Generally Applied Also Apply to Medical Care.

Mr. Justice Hugo Black eloquently discussed the purpose of the Sherman Antitrust Act. He wrote,

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act is competition. And to this end, it prohibits "Every contract, combination or conspiracy in restraint of trade or commerce among the several states."

Northern Pacific Ry. Co. v. *United States,* 356 U. S. 1, 4-5 (1958).

For many years health care interests and "organized" medicine have sought to be viewed in a different light than other sectors of the American economy. To a degree, they were successful.

However, this Court, in 1982, eliminated what lines of difference had been drawn when it handed down its opinion in *Arizona* v. *Maricopa County Medical Society*, —— U. S. ——, 102 S. Ct. 2466 (1982). Observed this Court,

> Nor does the fact that doctors—rather than nonprofessionals—are the parties to the price-fixing agreements support the respondents' position. In *Goldfarb* v. *Virginia State Bar*, 421 U. S. 773, 788, n. 17 [95 S. Ct. 2004, 2013, n. 17, 44 L. Ed. 2d 572] (1975), we stated that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." See *National Society of Professional Engineers* v. *United States*, 435 U. S. 679 [98 S. Ct. 1355, 1367, 55 L. Ed. 2d 637] (1978). The price-fixing agreements in this case, however, are not premised on public service or ethical norms. The respondents do not agree, as did the defendants in *Goldfarb* and *Professional Engineers*, that the quality of the professional service that their members provide is enhanced by the price restraint. The respondents' claim for relief from the *per se* rule is simply that the doctors' agreements not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it

easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry. The argument quite obviously is inconsistent with [*U. S.* v.] *Socony-Vacuum* [*Oil Co.*, 310 U. S. 150, 60 S. Ct. 811, 84 L. Ed. 1129]. In unequivocal terms, we stated that, "[w]hatever may be its peculiar problems and characteristics, *the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike.*" 310 U. S., at 222 [60 S. Ct. at 843]. We also stated that "[t]he elimination of so-called competitive evils [in an industry] is no legal justification" for price-fixing agreements, *Id.*, at 220, [60 S. Ct. at 843] yet the Court of Appeals refused to apply the *per se* rule in this case in part because the health care industry was so far removed from the competitive model. Consistent with our prediction in *Socony-Vacuum, Id.*, at 221 [60 S. Ct. at 843] the result of this reasoning was the adoption by the Court of Appeals of a legal standard based on the reasonableness of the fixed prices, an inquiry we have so often condemned. *Finally, the argument that the per se rule must be rejustified for every industry that has not been subject to significant antitrust activity ignores the rationale for per se rules,* which in part is to avoid "the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large

> whether a particular restraint has been unreasonable—an inquiry so often wholly fruitless when undertaken." *Northern Pac. R. Co.* v. *United States, supra* 356 U. S. at 5 [78 S. Ct. at 518]. (Emphasis added).

Arizona v. *Maricopa County Medical Society,* —— U.S. ——, 102 S. Ct. 2466, 2475-77 (1982).

Unequivocally, this Court has left no room for discussion regarding whether the federal antitrust laws, and the *per se* rule of those laws, apply to health and medical care. Accordingly, the purposes of the antitrust laws, as espoused by Mr. Justice Black in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958), must apply to health and medical care. That application of the federal antitrust laws to health and medical care is underscored by this Court's reference to physicians and surgeons as "individual competing entrepreneurs" in *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982). The AAPS submits that physicians and surgeons are, in fact, "individual competing entrepreneurs"; that they conduct their practices as such; and that they perceive themselves, in economic terms, as competitors.

As physicians and surgeons are "individual competing entrepreneurs," the exclusive contract which is the subject of the within action, by its very nature, must be violative of the Sherman Act, 15 U.S.C. §1. The exclusive contract, as outlined hereinabove, prevents Edwin G. Hyde, M.D., a competing entrepreneur, from entering the relevant market and competing. For anesthesiologists who presently compete in hospitals,

the entry into such an exclusive contract by the hospital and a single provider will eliminate many of them from competition. As outlined hereinabove, the exclusive contract forecloses those competitive factors found in the inner-hospital and inner-hospital medical staff market from favorably affecting the price of anesthesiology. With an exclusive contract, the price for anesthesiology services will be fixed, and there will be no market incentive for that price to ever decrease or stabilize. The profit motive of both the hospital and contracting anesthesiologist will continually pressure the fixed price upward.

B. The Exclusive Contract is a "Tying Arrangement"

The exclusive contract between the hospital and anesthesiologist group is, indeed, a "tying arrangement" as well as a basic restraint upon trade. As stated in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 5-6 (1958), "a tying arrangement may be defined as an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier." As indicated in *Northern Pacific,* the seller of the "tying product," here, the hospital, must have some "control or dominance" over the product it sells. *Id.* Mr. Justice Black referred to that "control or dominance" as being sufficient to exercise "power and leverage" in the market for the tied product. *Id.*

This Court further defined the confines of that "control or dominance" in the market for the tying product in *Northern Pacific*. Mr. Justice Black wrote,

> While there is some language in the Times-Picayune opinion which speaks of "monopoly power" or "dominance" over the tying product as a necessary precondition for application of the rule of per se unreasonableness to tying arrangements, we do not construe this general language as requiring anything more than sufficient economic power to impose an appreciable restraint on free competition in the tied product (assuming all the time, of course, that a "not insubstantial" amount of interstate commerce is affected)

Northern Pacific Ry. Co. v. *United States*, 356 U. S. 1, 11 (1958).

Sufficient market power over the tying product to exercise power and leverage over the market for the tied product is the standard.[5]

Here, the hospital, within the market place it dominates—the area where its medical staff members maintain their medical offices and residences and the area where would-be patients may enter the hospital conveniently and quickly—controls absolutely the rooms, equipment and personnel necessary for the use of the surgeons and other physicians who perform operations. The hospital has the necessary "control or dominance" over the product it sells.

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[5]Compare *Northern Pacific Ry. Co.* v. *United States*, 356 U. S. 1 (1958); *International Salt Co.* v. *United States*, 332 U. S. 392 (1947); *Time-Picayune Pub. Co.* v. *United States*, 345 U. S. 594 (1953); and *IBM Corp.* v. *United States*, 298 U. S. 131 (1936).

By entering into an exclusive contract with an anesthesiologist, the hospital, indeed, "ties" its product to the use of the exclusive anesthesiologist. In order for any patient to receive any surgical service in the hospital, he or she *must* use the anesthesiologist under contract.

The exclusive contract, here, is a classic "tying arrangement," and, as such, is a *per se* violation of the Sherman Antitrust Act. *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958).

The buyers of health care services, contrary to the assertions of Petitioners, do exercise choice regarding anesthesiologists. AAPS member anesthesiologists have competed for business in the past, and do now. Just as patients listen to their own private physicians and surgeons regarding what hospital in which they will be admitted, patients also, through their physicians and surgeons, choose an internist, surgeon, heart specialist, urologist, anesthesiologist, etc.

Unequivocally, referrals from physician to physician enable a patient to make choices. Accordingly, the United States Court of Appeals was correct when it addressed the exclusive contract as a vehicle which undermined patient choice.

As the foregoing is true, any "tying arrangement" involving the hospital—which provides the atmosphere or "place" where certain health care is provided—and a provider of a specialty service in health care undermines the policy of the Sherman Act that "competition rule(s) the marts of trade." To paraphrase Mr. Justice Black, the exclusive contract conditions the sale of

the hospital as a "place" where certain health services are provided on the purchase of the specialty service. The seller—the hospital—thereby coerces the abdication of the buyer's—the patient himself or herself or through his or her physician or surgeon—independent judgment as to the merits of the "tied" specialty service, "and insulates the specialty service from the competitive stresses of the open market." *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 10 (1958).

The exclusive contract must be a *per se* violation of the Sherman Act.

C. Any Defense of Petitioners That the Exclusive Contract Enhances Quality Medicine is Not Well Taken

Often in health care antitrust cases, the defense of "quality" is raised. Such was true in *American Medical Ass'n* v. *United States,* 317 U. S. 519 (1943); *In re American Medical Ass'n,* 94 F.T.C. 701 (1979), *aff'd* 638 F. 2d 443 (2d Cir., 1980), *aff'd* —— U. S. —— 102 S. Ct. 1744 (1982); *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982); and *Blue Shield of Virginia* v. *McCready,* —— U. S. ——, 102 S. Ct. 2540 (1982). AAPS, unequivocally, does not state here that legitimate quality of care concerns are unimportant. They are important. Quality of care, however, has often been used by the health care industry as a convenient smokescreen for behavior which does not have quality of care as its rationale at all. In health care, particularly, it is easy to pose the defense of quality of care to legitimize a host of anticompetitive activities.

Here, quality could hardly be said to have been enhanced by an exclusive contract. Rather, AAPS believes that the commentary of Mr. Justice Black in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 5 (1958) to be most appropriate when he wrote,

> . . . the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions.

AAPS believes that the foregoing language is the foundation for the federal antitrust laws, and that no defense of "quality" here should cause the instant "tying arangement" to be treated differently than in other industries.

IV

AN EXCLUSIVE CONTRACT BETWEEN A HOSPTAL AND AN ANESTHESIOLOGIST IS NOT A VERTICAL INTEGRATION, BUT, RATHER, A HORIZONTAL ARRANGEMENT BETWEEN PROVIDERS, AND, ACCORDINGLY, THE *PER SE* RULE APPLIES

The argument heretofore raised by the Attorney General of the United State, as *amcus curiae,* that an exclusive contract between a hospital and an anesthesiologist is a vertical integration, and, accordingly, is not subject to the *per se* analysis is totally fallacious. AAPS states that even if the Attorney General could make a plausible argument for his proposition (which

he cannot), so what? Exclusive contracts of the type herein discussed restrain trade by eliminating competition, blocking new entrants into a given market, and cancelling all market forces which favorably affect, among other things, the price of the service and product. No narrow, technical hairsplitting may salvage a practice so adverse to the fundamental principles embodied in the Sherman Antitrust Act.

Unquestionably, exclusive contracts between hospitals and anesthesiologists cannot be viewed as verticle integrations. The relationships between a hospital and the services and products offered by the members of its medical staff involved in all the varied specialties, e.g. surgery, internal medicine, urology, radiology, anesthesiology, ophthalmology, oral surgery, obstetrics and gynecology, proctology, neurology, among others, and even non-medical doctor specialties like podiatry, cannot be viewed as the Attorney General seeks this Honorable Court to examine them.

Undeniably, those relationships between a manufacturer and its various dealers or jobbers differ from the relationships between a hospital and the individual providers of medical and surgical care on its medical staff. Health care, as delivered in a hospital setting, does not encompass separate "levels" of delivery as manufacturing encompasses "levels" of production. The most dramatic difference in the two models is found in the salient fact that decisions made with respect to the delivery of health care in a hospital are not necessarily made by the hospital but by the individual providers of medical care on its medical staff.

Medical staffs in hospitals—public and private—are autonomous, self-governing bodies composed of competitors in the practice of medicine's varied specialties.

Customarly, when an anesthesiologist seeks admission to the medical staff of a hospital, he or she must first be approved by the Credentials Committee and Executive Committee of the Medical Staff. If the anesthesiologist is not approved, an *ad hoc* committee of medical staff members conducts a hearing on the question. Though the hospital governing board usually has the ultimate authority to approve medical staff membership, the medical staff, in most instances, makes the critical decisions. The use of anesthesiology is controlled by consults with surgeons and, possibly, physicians of other specialties. Again, the use of the professional service is determined by inner-hospital medical staff decision-making, not by the hospital.

The autonomy of the medical staff is underscored by the fact that medical staffs, uniformly, have bylaws—contractual in nature—entered into by and between them and the hospitals. Those bylaws traditionally create the departments into which medical staffs are divided, including the department of anesthesiology. The by-laws, as well, provide procedures for medical staff admissions, including the committees before which an applicant must appear in order to receive consideration for staff membership.

In typical larger medical staffs there are multiple surgeons, multiple internists, multiple urologists, etc. In fact, there are usually so many of each specialty that

they are, in the medical staff bylaws, departmentalized, with each department electing its own officers.

As stated hereinabove, the decision of what "specialist" to use, be that specialist an anesthesiologist, surgeon, internist, obstetrician, etc., is made either by the patient, or, in most cases, by the patient's personal, physician or surgeon based upon that physician's or surgeon's judgment of who is the better professional or, simply, what professional the physician or surgeon likes or with whom he or she better works. Thus, the choice of anesthegiologist in a non-exclusive contract context, is usually determined by market forces which originate within the hospital medical staff.

Whether a particular physician or surgeon "likes" or "prefers" a particular anesthesiologist, would, most likely, not be considered if the anesthesiologist has a bad reputation, is incompetent, charges exhorbitantly or is difficult to work with. Only the *market* can insure quality; only the *market* can best insure fair pricing.

All of the foregoing are inner-hospital medical staff factors which the Attorney General has failed to consider.

Manifestly, there is no verticle integration here.

Because of the foregoing, one cannot view the hospital as the manufacturer at the end of a process involving dealers and jobbers. There exists absolutely no comparison.

The hospital offers only a "place" where "independent competing entrepreneurs" offer their special health care services. The hospital is not akin to the manufacturer at the end of a long process of manu-

facturing. Rather, the hospital offers but the "place" for the performance of health care services. It is a "place" where multiple surgeons, multiple internists, multiple urologists, multiple obstetricians and gynecologists, multiple gastroenterologists, multiple anesthesiologists, etc., all departmentalized and all autonomously organized and self-governing, compete with one another in the offering of their specialty within the hospitals walls.

AAPS submits that if the hospital actually seeks to vertically integrate the medical professionals into itself it would *employ* them.

Petitioners assert that the exclusive contract here is a contract of employment. AAPS states that the exclusive contract here is no such thing! If Petitioners meant to *employ* the anesthesiologists, they would not have entered into an exclusive contract, but would have *employed* the group. The exclusive contract here recognizes that the anesthesiologist is a private, practicing provider group performing professional health care services. The anesthesiologists under the exclusive contract are members of the medical staff capable of holding elective office, and representing all private, practicing medical staff members. The anesthesiologists under the exclusive contract submit their own statements for services rendered. The group is not paid a salary, nor are taxes and social security withheld from payment. It is interesting to note that Petitioners must recognize the difference between the exclusive contract as a horizontal arrangement, and, employment as a verticle integration since so much of their defense

is based upon their assertion that the exclusive contract, here, is an employment question. Such, of course, does not pass muster as a matter of fact.

In all respects, the anesthesiologist under the exclusive contract is a private, practicing physician. The exclusive contract at issue here is no verticle integration. Rather, because hospitals rely upon an autonomous medical staff for most decision-making and fact-finding with regard to admissions to the staff of the hospital, and rely upon the medical staff for nearly all decisions regarding the administration of health care services, the relationship is purely horizontal. As such, the *per se* rule must apply.

CONCLUSION

For all the reasons set forth above, the *amicus curiae* urges that the decision of the United States Court of Appeals for the Fifth Circuit be affirmed.

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